The Governor's Summit on Providing Mental Health and Substance Abuse Services to Returning Combat Veterans and their Families
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Summary Report

Prepared by members of the Veterans Summit Planning Committee:

Wei Li Fang, Ph.D.
Denisse Marion-Landais Ambler, M.D.
Worth Bolton, M.S.W.
Debbie Crane
Joe Donovan
Fred Johnson
Everett Jones, M.D.
Harold Kudler, M.D.
Michael Lancaster, M.D.
James Martin, Ph.D.
Anthony McLeod
Charlie Smith
Flo Stein, M.P.H.
Kristy Straits-Tröster, Ph.D., A.B.P.P.

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Co-sponsored by the Governor's Office of North Carolina; the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), Department of Health and Human Services (DHHS); the Department of Veterans Affairs (VA); the Department of Defense (DoD); the Governor's Institute on Alcohol and Substance Abuse, Inc.; the Mid-Atlantic Addiction Technology Transfer Center; Substance Abuse and Mental Health Services Administration (SAMHSA); and GlaxoSmithKline.

Executive Summary

The *Governor's Summit on Returning Combat Veterans and their Families* is the beginning of a partnership between State and Federal Government, community providers, and programs. It is also the beginning of an ongoing process in which mental health and substance abuse service needs of veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) will be identified and addressed through specific recommendations and concrete plans and timelines. By exchanging information about their respective agencies' assets and goals and identifying strategic partnerships, Summit attendees began the work of articulating an integrated continuum of care that emphasizes access, quality, effectiveness, efficiency, and compassion. Principles of resilience, prevention, and recovery were emphasized along with state-of-the-art clinical services as part of a balanced public health approach. The product envisioned is a referral network of informational, supportive, clinical, and administrative services that will comprise a system through which citizens of North Carolina will have access to post-deployment readjustment assistance for veterans and their families.

While content presentations were the focus of the morning, four discussion groups were conducted simultaneously in the afternoon. Each discussion group issued specific recommendations, which are outlined below:

Discussion Group #1: Identifying available resources for combat veterans and their families

- Train STR (Screening, Triage, and Referral) staff, CARE-LINE staff, and potential providers throughout the state.
- Develop a visual road map for each service system.
- Identify a named point-of-contact within each service system [e.g., Department of Veterans Administration (VA), Department of Health and Human Services (DHHS), Department of Labor (DOL), and Department of Public Instruction (DPI)] so that combat veterans and their families may easily access the system (concept of "no wrong door").

Discussion Group #2: Ensuring engagement and support of combat veterans and their families

- Develop a seamless transition plan across agencies to enable service providers' provision of the right information to the right person at the right time.
- Proactively conduct outreach, where simple, clear messages in multiple formats are provided to combat veterans and their families.
- Suggest Public Relations campaign to alert veterans to resources available in the system (e.g., billboards, posters).

Discussion Group #3: Enhancing resiliency and improving readjustment

- Request that the Governor write personalized letters to veterans and their family members expressing appreciation for their service to our country, identifying a select set of access information and charging them with a new mission in the service of the state and their local communities.
- Develop and disseminate informational pocket cards for veterans and their families and for health and behavioral health care providers.
- Effectively utilize VA care managers to work with service members and their families over time.

Discussion Group #4: Accessing formal mental health services

- Provide training at all levels coordinated with the best practice models identified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and in the Department of Defense (DoD) and Department of Veterans Affairs (VA) systems. Use resources identified in the DoD and VA systems for training in the public system.
- Work with all stakeholders, connecting existing resources.
- Expand the Citizen-Soldier Support Program throughout the state.
- Work with the university system, Area Health Education Centers, and other partners to develop and disseminate products and educate primary care and behavioral health care personnel.
- Work with the University of North Carolina (UNC) Health Information (Medical Library Services) to disseminate relevant information to veterans and their families as well as to health and behavioral health providers.

Overview

On March 16-18, 2006, three members of the Planning Committee attended *The Road Home: The National Behavioral Health Conference on Returning Veterans and Their Families* in Washington, DC. Sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) in partnership with the Therapeutic Communities of America, the purpose of the conference was to bring together community mental health and substance abuse treatment providers to discuss evidence-based strategies for restoring hope and building resiliency in OEF (Operation Enduring Freedom) and OIF (Operation Iraqi Freedom) veterans, active-duty service members, reservists, National Guard members, and their families. This conference served as a catalyst for the North Carolina Governor's Summit, with the first planning meeting occurring shortly after the national conference.

After nearly six months of planning, Governor Michael Easley hosted the *Governor's Summit on Returning Combat Veterans and their Families* in Research Triangle Park, North Carolina on September 27, 2006 (see Appendix A for a copy of the agenda and list of participants). Co-sponsors included the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), Department of Health and Human Services (DHHS); the Department of Veterans Affairs (VA); the Department of Defense (DoD); the Governor's Institute on Alcohol and Substance Abuse, Inc.; the Mid-Atlantic Addiction Technology Transfer Center; and SAMHSA. GlaxoSmithKline graciously offered their conference facilities and services for the meeting.

Co-chaired by Michael Lancaster, MD, Chief of Clinical Policy, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, North Carolina Department of Health and Human Services, and Harold Kudler, M.D., Acting Director, Post Deployment Mental Illness Research, Education and Clinical Center (MIRECC), Veterans Health Administration, Department of Veterans Affairs, the purpose of the Summit was to bring together key leaders of North Carolina State Government, the Department of Veterans Affairs, and the Department of Defense, with representatives of provider and consumer groups to share essential information and promote best practices in the service of returning veterans of military service in Afghanistan and Iraq and their families. Governor Easley and Secretary Carmen Hooker Odom emphasized the importance of creating a continuum of care for OEF and OIF veterans once they return to their home communities. Providing timely and effective mental health and substance abuse services was considered to be critical, with Governor Easley charging participants to develop new ideas that would help veterans succeed in returning to their families, their jobs, and their communities.

Presentations

Speakers laid the groundwork for what was discussed in the small groups during the afternoon session. A synopsis of each presentation is provided in the following paragraphs (see Appendix B for a copy of the PowerPoint presentations).

COL Edward O. Crandell, Ph.D., Chief, Department of Behavioral Health, Womack Army Medical Center, *Soldier Behavioral Health and the Deployment Cycle*. COL Crandell addressed the stages of the emotional cycle of deployment; pre-deployment, combat and non-combat deployment stressors; post-deployment adjustment; and Battlemind training and "resetting" soldiers. He discussed challenges that veterans and their families face prior to, during, and after deployment and described how Battlemind training can help military personnel transition to

civilian life. He reported that a similar Battlemind training program is being developed for family members. COL Crandell also identified key resources for veterans and their families.

CAPT Monica Mellon, USMC and CAPT Richard Welton, USN, *The Three-Legged Milk Stool Approach*. CAPT Mellon discussed the Marine Operational Stress Surveillance and Training (MOSST) Program, which helps prepare service members and their families during pre-deployment, deployment, transition, and post-deployment. Education and support resources are available to address family readiness issues. CAPT Welton explained that the Navy provides health services to Marines and presented information on the Deployment, Return, Reunion Program (DRRP).

Harold Kudler, M.D., Post Deployment Mental Illness Research, Education and Clinical Center (MIRECC), Veterans Health Administration, *Strategies in Service to New Combat Veterans and their Families*. Dr. Kudler provided an overview of current approaches across the DoD/VA continuum of care. He emphasized a public health approach that provides outreach, education, and emotional support to all returning veterans and their family members. While triage to mental health services must be available when appropriate, Dr. Kudler noted that all veterans and their families deal with significant adjustment stress during and after deployment. He therefore recommended that population-based outreach should be made available to them, all with the aim of increasing resiliency rather than simply screening for new diagnoses.

Angeline Martin Woodson, Ph.D. and SFC Kurtis Cherry both spoke about their experiences as service members and the impact of their experiences on their personal lives. Dr. Woodson focused on post-deployment and how she, herself, coped with feelings of depression, loneliness, and alienation. SFC Cherry talked about experiences that Iraq veterans commonly have when they return home and how these experiences can affect their personal lives and their families. Even though they want normalcy in their daily lives, this can be very difficult to achieve. Tension can lead to arguments, domestic violence, alcohol and/or drug abuse, and separation or divorce. He requested that programs that help Reservists be continuously improved so that support can be extended and strengthened.

Mrs. Lil Ingram was the luncheon speaker. Even as a National Guard spouse, she recalled that she had not considered what it meant for her husband to be deployed until he was called up. She spoke movingly about her experiences and those of other Guard families she has known. In addition Mrs. Ingram talked about her interest and involvement in programs that help children of National Guard and other Reserve Component members. She identified three programs—the Kids on Guard developed by the Morrisville Family Assistance Center; the Prevention and Relationship Enhancement Program (PREP); and two-day institutes for teachers and counselors, developed by the Department of Public Instruction and the North Carolina Board of Education. She also mentioned that the Citizen-Soldier Support Program, a national demonstration hosted by the University of North Carolina at Chapel Hill, works with the National Guard and other Reserve Component family programs to mobilize local communities to support citizen-soldiers and their loved ones.

Discussion Groups

Four discussion groups were held simultaneously in the afternoon. A description of each group follows, with key points identified.

1. Identifying available resources for combat veterans and their families, with James A. Martin, Ph.D., BCD, Colonel, U.S. Army (Retired) and Director, Citizen-Soldier Support Program, as facilitator and Flo A. Stein, MPH, as recorder

Different participating groups and agencies each address the needs of returning veterans and their families, but they do not all address the same needs, and few, if any, address all their needs. This discussion group will work on identifying what services are available, where the natural interagency alliances are, what services need further development, and what needs are not currently being addressed..

The group's discussion centered on four themes, all related to communication:

- Messages and the information that they contain about services and benefits may be overwhelming and may need to be simplified, repeated, and/or explained in multiple ways. Both the message and the method of conveying the message are important.
- Resources need to be coordinated so that they are disseminated throughout the state and across agencies and organizations. Partnerships need to be further developed and expanded between the military; Veterans Affairs; state, regional, and local agencies; private and public entities; educational institutions; and nonprofit organizations. Because resources are not evenly distributed across the state, procedures need to be in place to ensure that veterans and their families can identify, access, and obtain adequate mental health and substance abuse services regardless of location.
- A visual road map needs to be created so that it is easier for veterans and their families to understand what services exist and how to access them. The VA has already accomplished this task for its own agency and it may be possible to model statewide efforts on this VA model.
- Making the initial contact may be difficult. Emphasis is on "no wrong door" so many portals are possible. One portal is Military OneSource, which provides easy access to services for veterans and their families. Staff at Military OneSource would need to know what is being offered by agencies and organizations in North Carolina at all levels. Another portal is the CARE-LINE Information and Referral Services operated by the Office of Citizen Services under the aegis of the NC Department of Health and Human Services. This toll-free line (800/662-7030) provides consumers with information on, or referrals to, human service providers across the state. An additional resource is the NC Consumer Health Information Portal under development at UNC-Chapel Hill. This resource will have a specific North Carolina focus and provide easy-to-use health information for all North Carolinians. This portal could be developed further to contain a specific easy-to-use area for veterans and their families. In addition, with some modifications, NC Health Info/MedlinePlus, now operated by the Health Sciences Library at UNC-Chapel Hill, could provide in-depth and comprehensive coverage of topics and services for veterans and their families.

This would benefit the public, as well as health and behavioral health professionals.

The group also identified resources:

- Governor's Advisory Commission on Military Affairs
- Veteran Employment and Training Services (VETS), US Department of Labor
- Vet Employment Project, Employment Security Commission
- NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, including crisis centers and STR units
- VA Regional Office
- NC Division of Veterans Affairs, including 97 county veterans services officers
- Vet Centers
- Family Assistance Centers
- Service-specific programs [e.g., Marine Operational Stress Surveillance and Training (MOSST) Program and the Navy Deployment, Return, Reunion Program (DRRP)]
- National Guard Family Program
- NC National Guard youth program (i.e., Kids on Guard)
- Military OneSource
- Citizen-Soldier Support Program
- American Legion
- Order of the Purple Heart
- Disabled American Veterans
- Veterans of Foreign Wars
- North Carolina Medical Society
- Mental Health Association
- Project CARE (Community Action Readiness Effort), Onslow Chamber of Commerce
- NC University System and Community College System
- UNC Health Sciences Library
- Area Health Education Centers

Identified as missing are centralized services for the Army Reserve, Marine Reserve, and Air Force Reserve members and families. Also missing is the involvement of certain community organizations, civic associations, faith communities, and community health systems (e.g., primary care, behavioral health, and public health).

2. Ensuring engagement and support of combat veterans and their families, with Everett R. Jones, Jr., M.D., as facilitator and Kristy Straits-Tröster, Ph.D., ABPP, as recorder

While returning veterans and their families are entitled to a host of services and supports, competing demands on their time, limited awareness of what services and supports are available, confusion about how such supports can assist them, concerns about career, impact of service use, and stigma regarding mental health services can all limit engagement. This discussion group will develop strategic approaches to engaging returning veterans and their families.

The group focused on barriers and solutions. Barriers included the following:

- access (e.g., transportation, hours of service, unavailability of service in some rural locations)
- lack of information or too much information, agencies unaware of what other agencies offer, requirements for accessing services
- bureaucracy (e.g., paperwork, time, delays),
- stigma (e.g., fear of engagement of the system, fear of discrimination, concern about negative impact on promotion or security clearance)
- denial, guilt, selflessness
- poor perception of the VA
- absence of additional supports (e.g., child care)
- lack of an integrated plan
- dispersion of veterans, making follow-up difficult

What is needed is a seamless transition plan across agencies to enable service providers' provision of the right information to the right person at the right time. VA care managers were identified as being in the position to assist veterans—to reach them wherever they are. Multiple formats (e.g., letters, pocket cards, text messaging, iPod streaming, blogs) of the same information are needed since individuals learn in different ways. Other solutions included outreach, a decision support tool (i.e., central depository available 24/7), public access, PDAs, cell phone advisories, peer counselors/buddies, and public relations. Possible "doors" were identified: Military OneSource, chaplains, Family Assistance Centers, doctors offices, state mental health, public health departments, primary care, social services, hospice, community action agencies, Employment Security Commission, schools, community colleges, universities, banks, grocery stores, barber shops, court houses, ABC stores, defensive driving and DUI classes, AA meetings, homeless shelters, jails, advertising (e.g., PSAs; ads on Superbowl, NASCAR/RBC, bulletin boards, late night television, and buses and in phone books; stickers on beer coolers; and posters in recreational areas and fast food drive-in windows). What is needed to move forward is money, infrastructure, decision support tools, gender-specific services, sharing standardized tools, and cross training and a common language across all agencies.

3. Enhancing resiliency and improving readjustment, with Harold Kudler, MD, as facilitator, and L. Worth Bolton, MSW, as recorder

All returning veterans and their families face challenges in dealing with deployment and readjustment. Even when the veteran does not meet criteria for mental health diagnoses, they and their families may be threatened by dysfunction and disability. This discussion group will work on identifying practical (and often non-medical) interventions that effectively improve resiliency and function among individuals and families.

This group looked at how trauma affects the resiliency of individuals, their families, and their communities. Resiliency was defined as an ongoing, dynamic process and essential as individuals strive for "hope, meaning, and a defined role."

The group identified barriers and assets for each level. At the individual level, perhaps the single greatest barrier to resiliency is the stigma which the veterans, themselves, associate with people who have readjustment problems. Other potential barriers included lack of strong family and/or community support systems, lack of phase-specific information about

readjustment, the fact that information changes over time, lack of direction and focus during the many phases of transition after deployment, and the need for “surge capacity” within each system of care. Assets included Military OneSource, VA’s Seamless Transition and Returning Veterans Outreach, Education and Care (RVOEC) Programs, the Vet Centers, Vet Service Officers, the MIRECC, the Citizen-Soldier Support Program, the Division of MH/DD/SAS, information and referral services of the local management entities (LMEs), and case management and care coordination systems.

At the family level, potential barriers included the family’s lack of understanding or knowledge about the military and its culture (especially in the Reserve Component); lack of information on how to access services for the veteran and/or family; the stigma associated with seeking help; the realities of multiple deployments; the isolation of families; and gender role challenges (important in this war in which approximately 15% of those deployed are women). Assets included the Family Assistance Centers, faith communities, Citizen-Soldier Support Program, K-12 schools, and primary care physicians, including pediatricians.

At the community level, potential barriers included lack of knowledge and understanding among the public and professionals and a tendency to confuse political ideology about the war with concerns about the warriors. Assets included the many people in the community who care and want to help; the Marines for Life Program; the MIRECC, the Citizen-Soldier Support Program; and the Family Assistance Centers.

The group identified the following overarching principles:

- Providers are not always well informed about potential resources.
- Education and personal contact provide the first links in a strong response process. These may best be provided by an identified case manager who is responsive to the veteran and the family's specific needs and who helps them navigate the system over time.
- There is a real need to define a clear role for veterans within society and a clear path for their next steps.

The group recommended that the Governor send personal thank you letters to each service member accompanied by a select list of resources with direct contact information, perhaps using a pocket card format. A separate letter to family members of the service member was also recommended. As a key step towards enhancing resilience, the Governor would conclude his letter by charging veterans and their families with a new mission in service to the state and their local communities.

4. Accessing formal mental health services, with Michael Lancaster, MD, as facilitator, and Wei Li Fang, Ph.D., as recorder

A subset of returning veterans and/or their families may develop the need for more substantive, "traditional" mental health services to address depression, anxiety disorders, PTSD, and substance abuse. Psychiatric conditions may arise in the veterans themselves, their spouses, or their children. The parents and other loved ones are also greatly impacted by these stressors and their needs should be recognized as well. This discussion group will begin to identify a means to assess and track service needs, the resources currently available by location and natural hand-off points and procedures.

The group discussed issues related to the identification of veterans and family members for mental health and substance abuse services and strategies for engaging them in the system. It was thought that having demographic information would be helpful in better serving service personnel including veterans and those who are still serving in the Guard and Reserve but who are no longer on active duty. Demographics of service personnel in North Carolina are not readily available although the Department of Defense has mailing addresses. The Department also sends a list of potential discharges by zip code, and this may aid VA case managers in discharge planning and follow-up.

Training at all levels is needed, from the veteran's spouse and/or parent(s) to school personnel, primary care physicians, community providers, librarians, benefits officers at community colleges, and faith communities. Improved communication is critical in order to connect existing resources, both in the military and in the community, and to increase awareness of stakeholders of what services exist and how to access them. For example, MIRECC is developing educational best practice models and tools (e.g., pocket cards) based on a recovery orientation for medical personnel, and these materials could be used in the broader health services community. Information on issues related to normal readjustment as well as Battlemind should be disseminated. Partnering with the university and community college systems and Area Health Education Centers across the state and academic detailing were also suggested.

MIRECC disseminates information and issues educational grant initiatives to train community members. Greater mobilization of existing resources is needed, with a statewide expansion of the Citizen-Soldier Support Program. To assist in community education, partnerships could form so that churches could provide the facility and child care while various agencies or organizations could provide education. A public relations campaign, utilizing billboards and newspaper inserts, was also suggested to increase awareness of OEF and OIF veterans and their families as well as the general public.

Of note is the fact that this war is very different from previous wars in that it has relied heavily on the National Guard and Reservists, and repeated deployments are common. Because the existing support system is geared toward military installations and is not necessarily a strong presence where the service members live, it has meant that health and other support personnel need to be more proactive in their outreach and education. GWOT (Global War on Terror) Coordinators at the five Vet Centers and staff in the various services that provide family readiness assistance are available to provide advocacy, education, outreach, and referral services. Counties vary in the breadth and scope of services offered.

Benefits are a concern, with local providers perceiving poor reimbursement rates through TriCare. Perhaps specific funds to support community-based services for veterans and their families could be requested from the General Assembly. To track service needs of this population, the North Carolina Treatment Outcome and Program Performance System (NC TOPPS) could be utilized.

Common themes across the four groups were that there should be “no wrong door” to which veterans and their families can come for help; the need to meet the veterans where they live; the need to better utilize and integrate existing resources through increased communication and collaboration; and the need to connect the dots for veterans and their families so that they may access and receive timely and effective mental health and substance abuse services.

Planning Committee Co-chairs:

Michael Lancaster, MD, Chief of Clinical Policy, NC DMH/DD/SAS, NC Department of Health and Human Services, Raleigh, NC 27699, 919/733-7011, 919/508-0951 (fax), Michael.Lancaster@ncmail.net

Harold Kudler, MD, Co-Director, Clinical Core, VISN 6 Mental Illness Research, Education and Clinical Center (MIRECC) and VISN 6 Mental Health Coordinator,, 508 Fulton Street (V6-MIRECC), Durham, NC 27705, 919/286-0411, ext. 7021, Harold.Kudler@va.gov

Planning Committee Members:

Denisse Marion-Landais Ambler, MD, Assistant Professor, Department of Psychiatry, UNC School of Medicine, 256 Medical School Wing D, CB # 7160, Chapel Hill, NC 27599-7160, Denisse_Marion-Landais@med.unc.edu

Worth Bolton, MSW, School of Social Work, University of North Carolina at Chapel Hill, CB #3550, Chapel Hill, NC 27599-3550, 919/962-4371, lwbolton@email.unc.edu

Debbie Crane, Public Affairs Director, Department of Health and Human Services, Debbie.Crane@ncmail.net

Joe Donovan, NAMI North Carolina, P.O. Box 985, Raleigh, NC, 27602, 919/931-1453, jdonovan@nami.org

Wei Li Fang, PhD, Director for Research and Evaluation, Governor's Institute on Alcohol and Substance Abuse, Inc., P.O. Box 13374, Research Triangle Park, NC 27709, 919/990-9559, 919/990-9518 (fax), Wei.Li.Fang@governorsinstitute.org

Fred Johnson, Information & Referral Specialist, Alliance of Disability Advocates, Center for Independent Living, P.O. Box 12988, Raleigh, NC 27605-2988, 919/833-1117; 919/833-1171 (fax); alliance@alliancecil.org, Fred.Johnson@alliancecil.org

Everett R Jones, Jr., MD, Senior Consultant, Clinical Core, VISN 6 Mental Illness Research, Education, and Clinical Center (MIRECC), 508 Fulton Street (V6-MIRECC), Durham, NC 27705, 919/286-0411, ext. 6112, Everett.Jones@va.gov

Anthony McLeod, Director of Operations, Governor's Institute on Alcohol and Substance Abuse, P.O. Box 13374, Research Triangle Park, NC 27709, 919/990-9559, 919/990-9518 (fax), amcleod@mindspring.com

Charlie Smith, Assistant Secretary for Veteran Affairs, Department of Veterans Affairs, Director, NC Division of Veterans Affairs, 1315 Mail Service Center, Raleigh, NC 27699-1315, 919/733-3851, Charlie.Smith@ncmail.net

Flo Stein, Chief of Community Policy, NC DMH/DD/SAS, NC Department of Health and Human Services, 3007 Mail Service Center, Raleigh, NC, 27699-3007, 919/733-4670, Flo.Stein@ncmail.net

Kristy Straits-Tröster, PhD ABPP, Assistant Co-Director, Clinical Core, VISN 6 Mental Illness Research, Education, and Clinical Center (MIRECC), 508 Fulton Street (V6-MIRECC), Durham, NC 27705, 919/286-0411, ext. 6032, straitstroster@biac.duke.edu or Kristy.Straits-Troster2@va.gov